100TH CONGRESS
1ST SESSION

H. R. 2508

To amend the Public Health Service Act and the Fair Labor Standards Act of 1938 to provide minimum health benefits for all workers in the United States.

IN THE HOUSE OF REPRESENTATIVES

MAY 21, 1987

Mr. WAXMAN (for himself, Mr. HAWKINS, Mr. CLAY, and Mr. MURPHY) introduced the following bill; which was referred jointly to the Committees on Education and Labor and Energy and Commerce

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A BILL

To amend the Public Health Service Act and the Fair Labor Standards Act of 1938 to provide minimum health benefits for all workers in the United States.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Minimum Health Benefits for All Workers Act of 1987".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

SEC. 101. MINIMUM HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES.

(a) REQUIREMENT.—The Public Health Service Act is amended by redesignating title XXIII as title XXIV and by inserting after title XXII the following:

"TITLE XXIII—MINIMUM HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES

"HEALTH BENEFITS

"SEC. 2301. (a) Each employer shall, in accordance with title III of the Minimum Health Benefits for All Workers Act of 1987, enroll each of its employees and their families in a health benefit plan.

"(b)(1) An employer which is a State or political subdivision of a State or an agency or instrumentality of a State or political subdivision and which does not enroll each of its employees and their families in a health benefit plan as required by subsection (a) shall not be eligible to receive a grant, contract, loan, or loan guarantee under this Act.

"(2) Any employer which does not enroll each of its employees and their families in a health benefit plan as required by subsection (a) shall be subject to section 332 of the Minimum Health Benefits for All Workers Act of 1987.

"(c) The terms used in this section have the meanings prescribed for them by section 303 of the Minimum Health Benefits for All Workers Act of 1987.".

(b) CONFORMING AMENDMENTS.—

(1) Sections 2301 through 2316 of the Public Health Service Act are redesignated as sections 2401 through 2416, respectively.

(2)(A) Sections 217(c), 465(f), and 497 of the Public Health Service Act (42 U.S.C. 218(c), 286(f), 289f) are each amended by striking out "2301" and inserting in lieu thereof "2401".

(B) Section 305(h) of such Act (42 U.S.C. 242c(h)) is amended by striking out "2313" each place it occurs and inserting in lieu thereof "2413".

TITLE II—AMENDMENTS TO FAIR LABOR STANDARDS ACT OF 1938 AND EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 201. MINIMUM HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES.

(a) HEALTH BENEFITS.—The Fair Labor Standards Act of 1938 is amended by adding at the end the following:

"TITLE II—MINIMUM HEALTH BENEFITS FOR EMPLOYEES AND THEIR FAMILIES

"HEALTH BENEFITS

"SEC. 201. Each employer shall, in accordance with title III of the Minimum Health Benefits for All Workers Act of 1987, enroll each of its employees and their families in a health benefit plan.

"(b) Any employer which does not enroll each of its employees and their families in a health benefit plan as required by subsection (a) shall be subject to section 332 of the Minimum Health Benefits for All Workers Act of 1987.

"(c) The terms used in this section have the meanings prescribed for them by section 303 of the Minimum Health Benefits for All Workers Act of 1987.".

(b) CONFORMING AMENDMENTS.—

(1) The Fair Labor Standards Act of 1938 is amended by striking out the first section and inserting in lieu thereof the following:

"SHORT TITLE

"SECTION 1. This Act may be cited as the 'Fair Labor Standards Act of 1938'.

"TITLE I—WAGES AND HOURS".

(2) The Fair Labor Standards Act of 1938 is amended by striking out "this Act" each place it occurs and inserting in lieu thereof "this title".

SEC. 202. PREEMPTION UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(2)) is amended—

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)", and

(2) by adding at the end the following:

"(C) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) any provision of the law of any State to the extent that such provision regulates, or otherwise provides any requirement relating to, contracts or policies of insurance issued to or under a health benefit plan under title III of the Minimum Health Benefits for All Workers Act of 1987.".

(b) CONFORMING AMENDMENT.—Paragraph (1) of section 3 of such Act (29 U.S.C. 1002(1)) is amended by adding at the end the following new sentence: "Such terms include a health benefit plan under title III of the Minimum Health Benefits for All Workers Act of 1987.".

TITLE III—REQUIREMENTS FOR HEALTH BENEFIT PLANS FOR EMPLOYEES AND THEIR FAMILIES

Part A—Requirement and Definitions

SEC. 301. EMPLOYER REQUIREMENT TO ENROLL EMPLOYEES IN HEALTH BENEFIT PLANS.

(a) IN GENERAL.—The provisions of this title apply to employers required to enroll employees in health benefit plans under section 2301(a) of the Public Health Service Act or under section 201(a) of the Fair Labor Standards Act of 1938.

(b) TYPES OF PLANS PERMITTED.—

(1) IN GENERAL.—Except as required under paragraph (2), a employer may meet the requirement of this title through any health benefit plan.

(2) PROVISION OF HEALTH BENEFIT PLANS THROUGH REGIONAL INSURERS.—

(A) EMPLOYERS REQUIRED TO USE REGIONAL INSURERS.—

(i) EMPLOYERS WITHOUT A HEALTH BENEFIT PLAN.—Except as permitted under subparagraph (B)(ii), each employer, which does not have in effect a health benefit plan on the day before the effective date (as defined in paragraph (3)(A)), must meet the requirement of this title through any health benefit plan of a regional insurer under section 323(a).

(ii) SMALL EMPLOYERS CHANGING PLANS.—Each small employer which—

(I) does have in effect a health benefit plan on the day before the effective date, but

(II) changes the insurer through which the plan is offered or changes the

plan from a self-insured plan to a plan of an insurer,

must then meet the requirement of this title through any health benefit plan of a regional insurer under section 323(a).

(B) CONTINUED USE OF REGIONAL INSURERS REQUIRED.—

(i) IN GENERAL.—If an employer meets the requirement of this title through any health benefit plan of a regional insurer under section 323(a), except as permitted under subparagraph (ii), the employer must continue to meet such requirement through such a plan.

(ii) EXCEPTION FOR CERTAIN LARGE EMPLOYERS.—A large employer (other than an employer which was a large employer on the day before the effective date) which meets the requirement of this title through any health benefit plan of a regional insurer under section 323(a) may elect to meet the requirement of this title other than through a health benefit plan of a regional insurer under section 323(a). If such an election is made and so long as the employer remains a

large employer, the employer no longer has the right under part C to meet the requirement of this title through any health benefit plan of a regional insurer.

(3) DEFINITIONS.—In this paragraph (2):

(A) The term "effective date" means January 1 of the second year that begins after the date of the enactment of this Act.

(B) The term "large employer" means an employer that is not a small employer.

(C) The term "small employer" means, with respect to a calendar year, an employer which employs an average number of employees of less than 25. The provisions of section 607(4) of the Employee Retirement Income Security Act of 1974 shall apply in the determination under this subsection of whether an employer is a large or small employer.

SEC. 302. COVERAGE OF FAMILY MEMBERS.

(a) REQUIREMENT.—Except as permitted under subsection (b)—

(1) enrollment of an employee in a health benefit plan under this title includes enrollment of the employee's family in the plan, and

(2) enrollment of the employee or the employee's family in a health benefits plan may not be waived by the employee.

(b) EXCEPTIONS TO AVOID DUPLICATE FAMILY COVERAGE.—

(1) SPOUSE OR PARENT EMPLOYED.—An employee, at the employee's option, may waive enrollment in a health benefit plan under this title for the spouse or a child of the employee but only for such period as the employee demonstrates that such spouse or child, respectively, is actually covered under a health benefit plan because the spouse or the child's other parent, respectively, is also an employee.

(2) CHILD EMPLOYED.—A child who is employed may waive enrollment in a health benefit plan provided by the child's employer during any period in which the child is covered under a health benefit plan under this title due to the employment of the child's parent.

(c) NONDISCRIMINATION.—An employer may not fail or refuse to hire, or may not discharge or otherwise discriminate against, any individual because the individual has a spouse or child and such employer is required under this title to enroll the spouse or child in a health benefit plan.

SEC. 303. DEFINITIONS.

In this title:

(1) The term "child" means an individual who is—

(A) under 18 years of age, or

(B) under 23 years of age and a full-time student.

(2) The term "employee" means, with respect to an employer, an individual who performs 17½ hours of service per week for that employer.

(3) The term "employer" means, with respect to a calendar quarter—

(A) an employer which is required to pay those it employs the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (or would be required to pay such wage but for section 13(a) of such Act); and

(B) any State or political subdivision thereof, or any agency or instrumentality thereof.

(4) The terms "family" and "family member" mean, with respect to an employee, the spouse and children of the employee.

(5) The term "health benefit plan" means a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974) which (except for purposes of sections 322(c)(3) and 401(b)) meets the requirements of section 311.

(6) The term "health insurance region" means such a region designated under section 321.

(7) The term "insurer" means an entity qualified under the law of a State to offer insurance or provide health benefits in that State.

(8) The term "nongovernmental employer" refers to an employer not described in paragraph (3)(B).

(9) The term "regional insurer" refers to an insurer certified as a regional insurer under section 322.

(10) The term "Secretary" means the Secretary of Health and Human Services.

(11) The term "State" includes the District of Columbia and, except for purposes of paragraph (7), also includes Puerto Rico, the Northern Mariana Islands, the Virgin Islands, Guam, and American Samoa.

Part B—Requirements for Health Benefit Plans

SEC. 311. GENERAL REQUIREMENTS; PERMITTING ACTUARIALLY EQUIVALENT PLANS.

(a) GENERAL REQUIREMENTS.—Subject to subsection (b), in order for a health benefit plan to meet the requirements of this part, the plan must—

(1) provide benefits for items and services in accordance with section 312;

(2) provide coverage of employees and family enrolled in the plan in accordance with section 313; and

(3) provide for premiums, deductibles, copayments, and coinsurance only in accordance with section 314.

(b) ACTUARIALLY EQUIVALENT PLANS PERMITTED.—

(1) IN GENERAL.—A health benefit plan also meets the requirements of this part notwithstanding that it—

(A) does not meet the requirement under section 312(a) that the plan provide benefits for the types of care described in paragraphs (1) through (3) of such section, or

(B) does not meet one or more requirements of section 314 (relating to premiums, deductibles, copayments, coinsurance, and limit on out-of-pocket expenses),

if the actuarial benefits under the plan (as defined in paragraph (2)) are not less than the actuarial benefits which would have applied if the plan met the requirements described in subsection (a). Nothing in this paragraph shall be construed as not requiring each plan to meet the requirements of sections 312(a)(4) and 313.

(2) ACTUARIAL BENEFITS.—For purposes of paragraph (1), a plan's "actuarial benefits" are the amount by which the total of the amounts payable as benefits under the plan exceed the amount of the pre-

miums, deductibles, copayments, and coinsurance payable by the employee under the plan, as determined on an actuarial basis per enrollee for a plan year.

SEC. 312. REQUIREMENTS RELATING TO COVERED ITEMS AND SERVICES.

(a) IN GENERAL.—Except as provided in subsection (b), a health benefit plan must include payment for—

(1) inpatient and outpatient hospital care (other than inpatient or outpatient mental health care);

(2) inpatient and outpatient physician services (other than mental health services);

(3) diagnostic and screening tests; and

(4) prenatal care and well-baby care.

(b) EXCEPTION.—Subsection (a) shall not be construed as requiring a plan to include payment for—

(1) items and services which are not medically necessary;

(2) routine physical examinations or preventive care; or

(3) experimental services and procedures.

(c) SPECIFICATION OF PRENATAL CARE AND WELL-BABY CARE.—The Secretary shall by regulation prescribe, and annually revise, a schedule specifying the amount, duration, and scope of prenatal care and well-baby care required

under subsection (a)(4). Subsection (b) shall not apply to such care provided in accordance with such schedule.

SEC. 313. REQUIREMENTS RELATING TO TIMING OF COVERAGE AND PROHIBITION OF PREEXISTING CONDITION LIMITATIONS.

(a) DATE OF INITIAL COVERAGE.—In the case of an employee (and family members) enrolled under a health benefit plan provided by an employer, the coverage under the plan must begin not later than the latest of the following:

(1) 30 days after the day on which the employee first performs an hour of service as an employee of that employer.

(2) The first day on which the employer is required to meet the requirements of this title.

(3) In the case of a health benefit plan which—

(A) has been provided by the employer since May 19, 1985, and

(B) is provided by an employer which provides interim coverage under subsection (b),

the earlier of (i) 6 months after the day on which the employee first performs an hour of service as an employee of that employer, or (ii) the date for initiation of coverage under the plan (as in effect on May 19, 1987).

(b) INTERIM COVERAGE REQUIREMENT.—Subsection (a)(3) shall only apply to an employer if the employer enrolls each employee, during the period the employee would otherwise be covered under a health benefit plan but for subsection (a)(3), in an interim plan that would meet the requirements of section 311 except that—

(1) the interim plan requires a premium that on a monthly basis exceeds the premium otherwise permitted under section 314(b), so long as the premium on a monthly basis does not exceed the monthly actuarial rate defined in section 314(b)(1)(B); or

(2) the interim plan requires deductibles and coinsurance that exceed the amounts otherwise permitted under section 314(b) and subparagraphs (A) and (B) of section 314(c)(1), so long as the interim plan meets the requirement of section 314(c)(1)(C) (relating to limitation on out-of-pocket expenses).

(c) PROHIBITION OF PRE-EXISTING CONDITION PROVISIONS.—A health benefit plan may not exclude or otherwise limit any individual from coverage under the plan on the basis that the individual has (or at any time has had) any disease, disorder, or condition.

SEC. 314. REQUIREMENTS RELATING TO PREMIUMS, DEDUCTIBLES, COPAYMENTS, COINSURANCE, AND LIMIT ON OUT-OF-POCKET EXPENSES.

(a) ENROLLEE COST-SHARING PERMITTED.—A health benefit plan may require an enrollee to pay for premiums, deductibles, and coinsurance amounts for coverage under the plan, but only if the premiums, deductibles, copayments, and coinsurance do not exceed the limitations imposed under this section.

(b) LIMITATION ON PREMIUMS.—

(1) MONTHLY PREMIUM LIMITED TO 20 PERCENT OF ACTUARIAL RATE.—

(A) IN GENERAL.—A health benefit plan may not require an employee to pay a premium—

(i) for coverage for a period of longer than one month, or

(ii) the amount of which on a monthly basis exceeds 20 percent of the monthly actuarial rate defined under subparagraph (B).

(B) MONTHLY ACTUARIAL RATE DEFINED.—For purposes of this title, the term ''monthly actuarial rate'' means, with respect to a health benefit plan in a plan year, the average monthly per enrollee amount which the employer providing the plan estimates, for enrollees under the plan during the year, would be necessary to

pay for the total benefits required under the plan (including administrative costs for the provision of such benefits and an appropriate amount for a contingency margin) during the year.

(C) APPLICATION ON BASIS OF FAMILY STATUS.—For purposes of this paragraph, a health benefits plan may provide for the premium to be applied, and the monthly actuarial rate—

(i) to be computed separately for employees without a family and for employees with a family, and

(ii) with respect to employees with a family, to be computed separately (I) for employees who have a spouse and any children, (II) for employees who have a spouse but no children, and (III) for employees who do not have a spouse but have children.

(2) NO PREMIUM FOR LOW INCOME EMPLOYEES.—

(A) IN GENERAL.—A health benefit plan may not require a premium for an employee whose hourly wage rate is less than the hourly wage rate specified in subparagraph (B).

(B) HOURLY RATE.—The hourly wage rate specified in this subparagraph for premiums paid in a plan year beginning in—

(i) 1988, is $4.19, or

(ii) a subsequent year, is the hourly wage rate specified in this subparagraph for the previous calendar year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the rate computed under clause (ii) is not a multiple of 1 cent it shall be rounded to the next highest multiple of 1 cent.

(3) PAYMENT OF PREMIUMS.—An employee enrolled under a health benefit plan is liable for payment of premiums required under that plan in accordance with this subsection.

(c) LIMITATION ON DEDUCTIBLES.—

(1) IN GENERAL.—Except as permitted under paragraph (2), a health benefit plan may not provide, for benefits provided in any plan year, for a deductible amount—

(A) which exceeds—

(i) $250, with respect to benefits payable for items and services furnished to any employee with no family member enrolled under the plan, or

(ii) $500, with respect to benefits payable for items and services furnished to any employee with a family member enrolled under the plan and to the employee's family; or

(B) for prenatal care or well-baby care described in section 312(a)(4).

(2) WAGE-RELATED DEDUCTIBLE.—A health benefit plan may provide for any other deductible amount instead of the limitations under—

(A) clause (i) of paragraph (1)(A), so long as the amount does not exceed (on an annualized basis) 1 percent of the total wages paid to the employee in the plan year, or

(B) clause (ii) of paragraph (1)(A), so long as the amount does not exceed (on an annualized basis) 2 percent of the total wages paid to the employee in the plan year.

(d) LIMITATION ON COPAYMENTS AND COINSURANCE.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), a health benefit plan may not—

(A) require payment of any copayment or coinsurance for an item or service in an amount that exceeds 20 percent of the cost of the item or service;

(B) require payment of any copayment or coinsurance for prenatal care or well-baby care described in section 312(a)(4); or

(C) require payment of any copayment or coinsurance for items and services required under section 312 furnished in a plan year for an employee after the employee has incurred out-of-pocket expenses under the plan that are equal to the out-of-pocket limit (as defined in paragraph (4)(B)).

(2) EXCEPTION FOR PREFERRED PROVIDERS.—If a health benefit plan establishes reasonable classifications of participating and nonparticipating providers of items and services, the plan may require payments in excess of the amount permitted under paragraph (1) in the case of items and services furnished by nonparticipating providers.

(3) EXCEPTION FOR IMPROPER UTILIZATION.—A health benefit plan may provide for copayment or

coinsurance in excess of the amount permitted under paragraph (1) for any item or service which an individual obtains without complying with any reasonable procedures established by the plan to ensure the efficient and appropriate utilization of covered services.

(4) LIMIT ON OUT-OF-POCKET EXPENSES.—

(A) OUT-OF-POCKET EXPENSES DEFINED.—In this section, the term "out-of-pocket expenses" means, with respect to an employee in a plan year, amounts payable under the plan as deductibles and coinsurance with respect to items and services provided under the plan and furnished in the plan year on behalf of the employee and family covered under the plan.

(B) OUT-OF-POCKET LIMIT DEFINED.—In this section, except as provided in subparagraph (C), the term "out-of-pocket limit" means for a plan year beginning in—

(i) the first calendar year that begins more than 1 year after the date of the enactment of this Act, $3,000, or

(ii) for a subsequent calendar year, the out-of-pocket limit specified in this subparagraph for the previous calendar year increased by the percentage increase in the

consumer price index for all urban consumers (U.S. city average, as published by the Bureau of Labor Statistics) for the 12-month period ending on September 30 of the preceding calendar year.

If the out-of-pocket limit computed under clause (ii) is not a multiple of $10, it should be rounded to the next highest multiple of $10.

(C) ALTERNATIVE OUT-OF-POCKET LIMIT.—A health benefit plan may provide for an out-of-pocket limit other than that defined in subparagraph (B) if, for a plan year with respect to an employee and the employee's family, the limit does not exceed (on an annualized basis) 10 percent of the total wages paid to the employee in the plan year.

Part C—Certification of Regional Insurers

SEC. 321. DESIGNATION OF HEALTH INSURANCE REGIONS.

The Secretary shall designate by regulation 6, 7, or 8 health insurance regions for purposes of this part.

SEC. 322. PERIODIC CERTIFICATION OF REGIONAL INSURERS.

(a) COMPETITIVE PROCEDURES.—The Secretary shall establish competitive procedures for the periodic certification of 2, 3, 4, or 5 regional insurers for each health insurance region for a defined period.

(b) APPLICATIONS.—No insurer may be certified as a regional insurer unless it submits to the Secretary an application for such certification in such form and at such time as the Secretary prescribes. Each such application shall include—

(1) specific descriptions of each of the health benefit plans the insurer proposes to offer under section 323(a) as a regional insurer; and

(2) such information needed for the Secretary to consider the items described in subsection (c).

(c) CONSIDERATIONS.—In reviewing applications for certification as regional insurers, the Secretary shall consider, with respect to each applicant—

(1) the price of health benefit plans proposed to be offered by the applicant,

(2) the quality and types of services to be provided under the plans,

(3) the experience of the applicant in providing and managing health benefit plans, and

(4) the financial stability of the applicant.

(d) CERTIFICATION.—Not later than one year after the date of the enactment of this Act, the Secretary shall first certify regional insurers for each health insurance region. The Secretary shall publish in the Federal Register a list of the regional insurers certified under this section. To the

extent possible, the Secretary shall certify 5 regional insurers for each region.

(e) EVALUATION AND DECERTIFICATION.—The Secretary shall periodically evaluate the performance of regional insurers under this part. Where the Secretary finds that a regional insurer is not substantially meeting the requirements of this part, the Secretary, after notice and opportunity for a hearing, may terminate the certification of the insurer. In such a case, the Secretary may provide for certification of another regional insurer for the health insurance region affected.

SEC. 323. REQUIREMENTS OF REGIONAL INSURERS.

(a) PLANS MUST OFFER.—Each regional insurer shall offer, to employers located in its health insurance region—

(1) 2 indemnity plans described in subsection (b)(1)—

(A) one of which provides only the minimum benefits required of a health benefit plan, and

(B) the other which provides benefits typical of the benefits offered under comprehensive health benefit plans offered in the region; and

(2) 2 managed-care plans described in subsection (b)(2)—

(A) one of which provides only the minimum benefits required of a health benefit plan, and

(B) the other which provides benefits typical of the benefits offered under comprehensive health benefit plans offered in the region.

In the case of plans described in paragraph (1)(A) or (2)(A), a regional insurer may provide optional, additional benefits for an additional premium.

(b) PLANS DESCRIBED.—

(1) INDEMNITY PLAN.—An indemnity plan described in this subparagraph is a health benefit plan—

(A) which makes payment with respect to items and services furnished by any provider licensed in the State to provide the items and services if—

(i) the provider is a type of provider covered under the plan;

(ii) the provider is not excluded from receiving payment under the plan on the basis of fraud, abuse, or incompetence (as determined under the rules and procedures of the plan); and

(iii) the plan does not differentiate in payment to providers under the plan based on a contractual arrangement (or lack thereof) between the plan and the provider; and

(B) under which an individual incurs an obligation or makes payment for covered item or service and the plan reimburses the individual or the provider of such services for the amounts payable for such item or service under the plan.

(2) MANAGED-CARE PLAN.—A managed-care plan described in this subparagraph is a health benefit plan under which items or services must generally be furnished either—

(A) by providers having a contractual relationship with the plan, or

(B) providers included on a list specified by the plan which consists of a group of providers in a State which is more restricted than all licensed providers in the State.

(c) COMMUNITY-RATED PREMIUMS.—Subject to section 324(b)(2), each regional insurer shall fix premiums for the plans required under subsection (a) under a community rating system for all employers. An insurer may not set or adjust such premiums based on the age or gender of employees (or their families) or on other factors relating to the projected or actual use of health services under the plan.

SEC. 324. MISCELLANEOUS PROVISIONS.

(a) SUBCONTRACTS.—Each regional insurer may enter into subcontracts with other entities in carrying out this part.

(b) ARRANGEMENTS WITH SMALL BUSINESSES.—

(1) IN GENERAL.—The Secretary shall encourage regional insurers to enter into appropriate arrangements with entities representing groups of small businesses (such as small business service bureaus and chambers of commerce) for the provision of adminstrative services with respect to small businesses enrolled in plans offered by the insurers.

(2) PREMIUM REDUCTION.—Each such insurer shall reduce the premiums otherwise charged for such plans to such small businesses by an amount which reflects the value of such administrative services.

(c) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance and enrollment forms to employers required under section 301(b)(2) to provide health benefit plans of regional insurers. In carrying out this subsection, the Secretary shall, to the maximum extent feasible, enter into contracts (to the extent and in such amounts as may be provided in advance in appropriation Acts) with small business service bureaus, chambers of commerce, and other entities with experience in providing health insurance services to small businesses.

Part D—Regulations and Enforcement

SEC. 331. REGULATIONS.

Within 6 months after the date of the enactment of this Act, the Secretary shall publish a notice of proposed rule making to carry out this title. Within one year after such date, the Secretary shall promulgate final rules to carry out this title. Such notice and final rules shall be made in accordance with section 553 of title 5, United States Code.

SEC. 332. ENFORCEMENT.

(a) CIVIL MONEY PENALTY AGAINST PRIVATE EMPLOYERS.—

(1) 10 PERCENT OF TOTAL WAGES.—Any nongovernmental employer which does not comply with section 302(c) or the requirements of section 2301(a) of the Public Health Service Act or section 201(a) of the Fair Labor Standards Act of 1938 in any calendar year is subject to a civil penalty of not more than 10 percent of the total amount of the employer's expenditures for wages for employees in that year.

(2) ASSESSMENT PROCEDURE.—A civil money penalty under this subsection shall be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court. The Secretary shall not assess such a penalty on an em-

ployer until the employer has been given notice and an opportunity to present its views on such charge.

(3) AMOUNT OF PENALTY.—In determining the amount of the penalty, or the amount agreed upon in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification of noncompliance by the Secretary.

(4) JUDICIAL REVIEW.—In any civil action brought to review the assessment of such a penalty or to collect such a penalty, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of the penalty, unless in a prior action such a trial de novo was held on the assessment.

(b) LIABILITY TO INDIVIDUALS FOR DAMAGES.—Any nongovernmental employer that knowingly does not comply with section 302(c) or the requirements of section 2301(a) of the Public Health Service Act or section 201(a) of the Fair Labor Standards Act of 1938 shall be liable for damages (including health care costs incurred) to the employee or the employee's family resulting from such failure to comply.

(c) STATE INELIGIBILITY FOR PUBLIC HEALTH SERVICE ACT FUNDS.—For a provision making States and political subdivisions thereof ineligible for funds under the Public

Health Service Act if they fail to enroll employees under health benefit plans, see section 2301(b)(1) of such Act.

(d) INJUNCTIVE RELIEF.—

(1) IN GENERAL.—Subject to paragraph (3), any individual injured or adversely affected or aggrieved by a violation of the requirements of section 302(c), section 2301(a) of the Public Health Service Act, or section 201(a) of the Fair Labor Standards Act of 1938 may bring an action in an appropriate district court of the United States to enjoin such a violation or to compel compliance with such requirement.

(2) COSTS AND FEES.—In any judicial proceeding under this subsection, the court, in its discretion, may allow the party bringing the action a reasonable attorney's fee as part of costs if the party substantially prevails.

(3) NOTICE.—At least 15 days before the date a party brings an action under this subsection, the party shall give notice by registered mail to the Secretary and the Attorney General. Such notice shall state the nature of the alleged violation and the court in which the action will be brought.

TITLE IV—EFFECTIVE DATE

SEC. 401. EFFECTIVE DATE.

(a) GENERAL RULE.—This Act, and the amendments made by this Act, shall take effect on January 1 of the second year that begins after the date of the enactment of this Act.

(b) SPECIAL TRANSITION.—In the case of an employer which, on the date of the enactment of this Act, has in effect a health benefit plan, this Act, and the amendments made by this Act, shall not apply until the first day of the second plan year that begins after the date of the enactment of this Act.

SEC. 402. POLICY RESPECTING ADDITIONAL BENEFITS.

(a) IN GENERAL.—After the date of the enactment of this Act, no employer will be required under title III to provide any health benefit in addition to the benefits required to be provided under section 312(a) (as in effect on the date of the enactment of this Act) unless—

(1) such additional health benefit is for a service which State medicaid plans (under title XIX of the Social Security Act) are required to cover for individuals receiving cash assistance under part A of title IV of such Act; and

(2) before the enactment of such requirement, the benefits and costs of requiring the provision of such ad-

ditional health benefit have been analyzed and considered by the Congress.

(b) CONSIDERATIONS.—(1) In carrying out subsection (a)(2) with respect to the consideration of a proposed additional health benefit, the Congress shall request a report from the Office of Technology Assessment, the Institute of Medicine of the National Academy of Sciences, or a public or nonprofit entity with expertise relating to health benefits. Any such report shall—

(A) analyze and summarize such proposed additional health benefit; and

(B) contain an estimate of the economic and health impacts of such proposed additional health benefit.

(2) Any such report shall be prepared in consultation with interested members of the public and with individuals and entities having expertise with respect to such proposed additional health benefit.

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